

# **STATUS REPORT TO THE LEGISLATURE**

## **CALIFORNIA CHILDREN'S SERVICES PROGRAM STUDY**

**May 2011**



**Department of Health Care Services  
Systems of Care Division**

# STATUS REPORT TO THE LEGISLATURE

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## **I. Background**

Senate Bill (SB) 853 (Chapter 717, Statutes of 2010) requires the Department of Health Care Services (DHCS) to seek support from one or more foundations to fund a study or studies of the California Children's Services (CCS) Program. The intent of this uncoded legislation is for DHCS to use the study findings to administratively streamline the CCS Program and facilitate the development of statewide policies and procedures to improve Program operations. SB 853 suggested six specific areas to be addressed in the CCS Program study, these areas are:

1. Systems analysis of core business processes and practices of the program, including the Service Authorization Requests (SARs), requests for durable medical equipment, and reimbursement processing;
2. Review of CCS provider certification and enrollment process;
3. Review of medical eligibility processing;
4. Oversight and monitoring of quality of care;
5. Identification of best practices for case management and care coordination functions including discharge planning; and
6. Identification of opportunities for the use of web-based tools telemedicine, e-prescribing, and other technologies to reduce costs and streamline.

This report addresses all six components of the CCS Program study; however, implementation of actions and/or recommendations to streamline the Program will be accomplished in a two-phased approach. Phase 1, currently being implemented, focuses on better utilization of technology when streamlining the core business process in areas such as SAR processing, and CCS Program oversight and monitoring. Phase 2, under development, will include systems analysis of core business processes and practices associated with requests for durable medical equipment; reimbursement processing; and identification of best practices for case management and care coordination functions, including discharge planning. We anticipate Phase 2 to be fully implemented within the next two years.

The Systems of Care Division (SCD) contacted the California Health Care Foundation and the Lucile Packard Foundation to determine whether their CCS-related studies already in progress would meet the mandates of SB 853. Although both foundations responded positively to DHCS' inquiry, the two foundations had already committed resources to two other CCS projects including the Lucile Packard Foundation's CCS demonstration model study and California Health Care Foundation's (Stanford University) CCS cost utilization and health condition data collection study. In late 2010, DHCS' Audits and Investigations Division conducted an internal review of the management operations of the CCS Program Sacramento Regional Office (SRO), which processes SARs for 24 dependent counties. This review addressed both short-term improvements and long-term solutions to the complex SAR process.

The Audits and Investigations Division has provided preliminary findings of their review, along with recommendations for improved business processing. In addition, SCD conducted independent “on-site reviews” of approximately 30 percent of the county CCS Programs using a “best practices” approach to gather data for program business operations improvements. The Audits and Investigations Division’s findings and SCD’s on-site reviews are as follows, and are listed in the same order of the six CCS Program review categories in SB 853.

**II. Systems analysis of core business processes and practices of the program, including the Service Authorization Requests, requests for durable medical equipment, and reimbursement processing**

Systems analysis of core business processes and practices of the program SAR requests will begin in Phase 1, and continue into Phase 2. Analysis of core business processes and practices associated with requests for durable medical equipment, and reimbursement processing will be addressed in Phase 2.

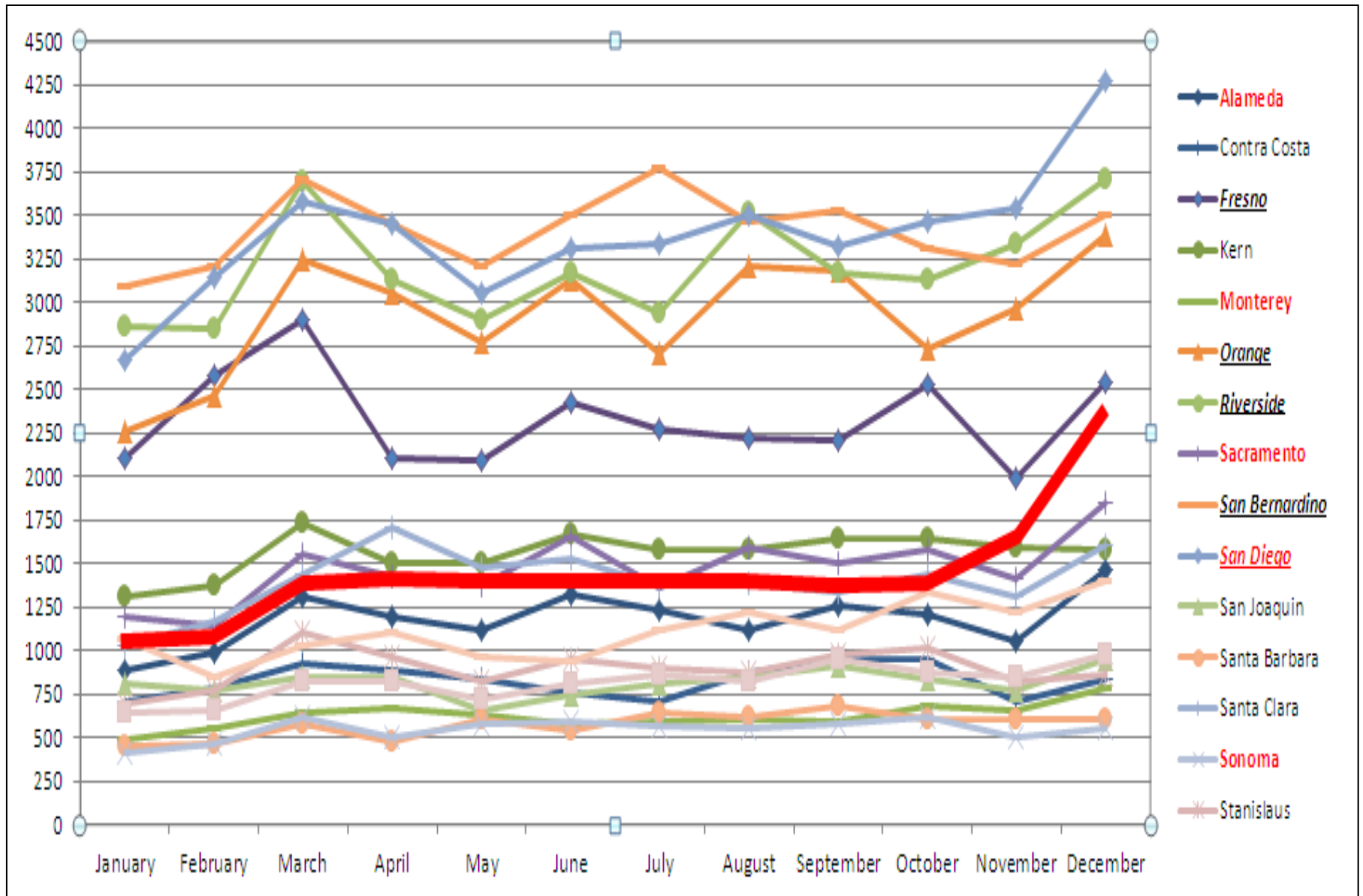
An internal analysis was conducted by the CCS Program to address recommended approaches to the Audits and Investigation Division findings. County CCS staff was observed and interviewed during site visits to identify basic and innovative electronic approaches to SAR processing and tracking, process flow, staffing needs, and policies and procedures.

CMSNet System (CCS case management and SAR system) information was accessed to identify current capabilities and shortcomings. A data mining component was included in the internal review to identify potential trends in the data and potential process gaps that may require further exploration.

Analysis of 15 counties that process over 500 SARs per month (typically large independent counties) indicated that SAR production is a fairly consistent process. These counties are identified in Chart A on the following page.

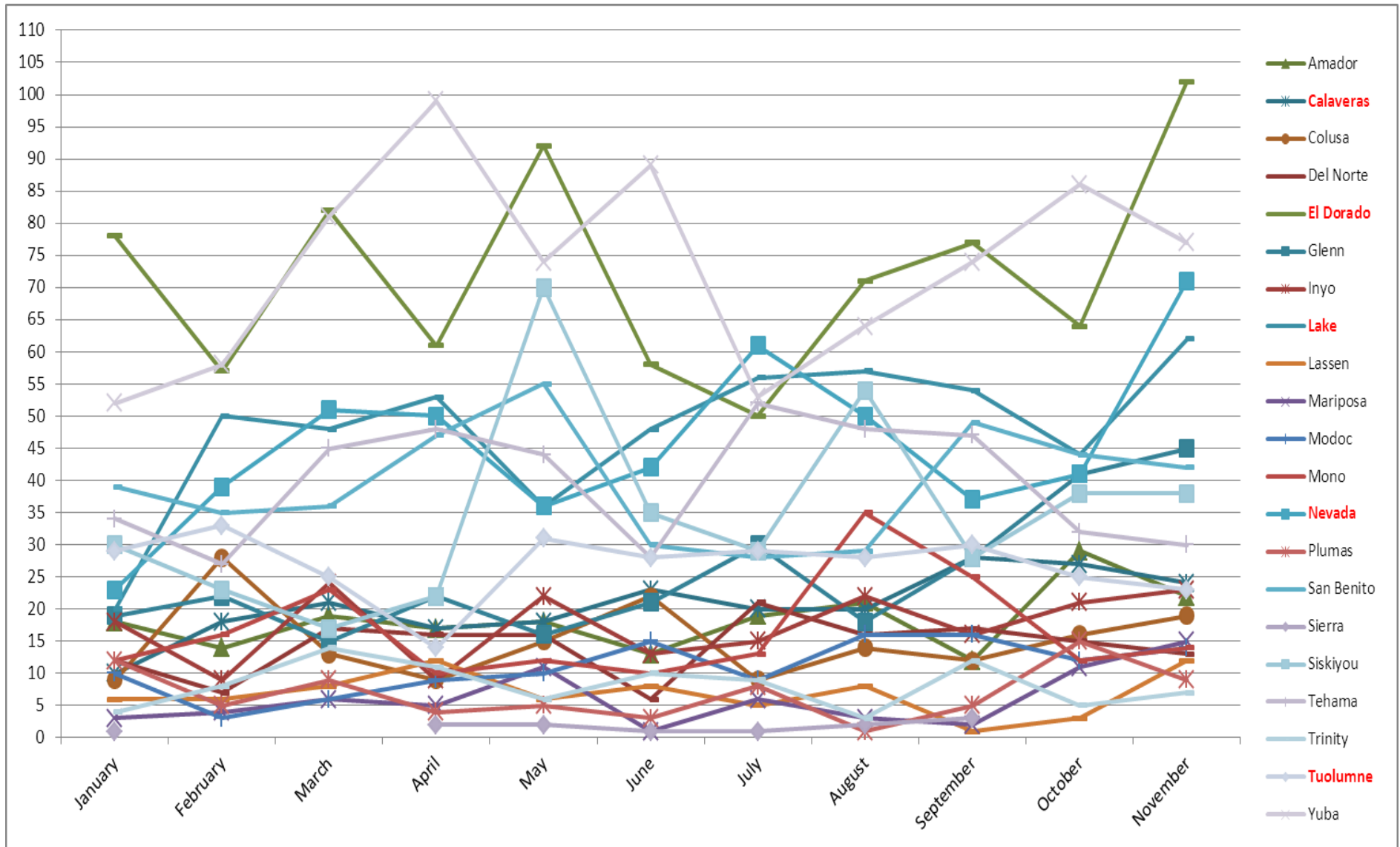
Chart B reflects the results of an analysis of 21 counties that process fewer than 100 SARs per month (small dependent counties), and indicates that SAR production in these counties is a fairly inconsistent process. Twelve of the dependent counties process an average of 25 SARs per month. Some counties dedicate staffing only 1-2 days per week to process SARs, which may contribute to the fluctuations shown in SAR production at the county level. These county shifts in production eventually manifest as radical shifts in SAR workload at the state CCS Program office.

Chart A



**SRO SAR production**  
Source: CMSNet database

Chart B



Source: CMSNet Database

Members of the County Health Executives Association of California, Children's Regional Integrated Service System, and CCS County Executive Committee were interviewed to select counties to be included in the site visit and best practices review.

Fourteen dependent counties (counties with populations under 200,000) and independent counties (counties with populations in excess of 200,000) were selected, visited, and analyzed to determine best practices and issues affecting county SAR production. Twenty-one percent of the counties reviewed were dependent counties. Initial analysis of the dependent county SAR processing data indicates that the SRO does not appear to be causing the radical shifts in SAR production reflected in the data. Further analysis of counties processing under 100 SARs per month is required to identify reasons for radical shifts in SAR production.

The table below provides a listing of both large and small counties included in the "best practices" and "issues" review, and reflects their respective average SAR production per month. SRO is also included in the table for comparative purposes.

#### **Average Monthly SAR Production for Studied Counties**

<b>Organization</b>	<b>Dependent or Independent County</b>	<b>Average Production Per Month</b>
Los Angeles	Independent	11,119
San Diego	Independent	5,970
Sacramento	Independent	1,774
Alameda	Independent	1,768
<b>Sacramento Regional Office</b>		<b>1,550</b>
Monterey	Independent	883
Sonoma	Independent	704
Butte	Independent	329
Solano	Independent	296
Napa	Independent	202
Mendocino	Independent	178
Marin	Independent	150
Lake	Dependent	68
Tuolumne	Dependent	42
Calaveras	Dependent	30

Source: CMSNet Database

## Operational Challenges

Each county studied, regardless of size, has operational issues; some issues are homogeneous to both dependent and independent counties, others are distinct to the type of county. The most critical operational challenges discovered during the study are described as follows:

	<b>Operational Challenges</b>	<b>Counties Studied</b>
1	Many providers do not use the standard SAR form to request service authorizations. Medi-Cal has an equivalent SAR process referred to as a Treatment Authorization Request (TAR) which requires standard form submission with all requests.	All
2	Incomplete information is submitted by providers and facilities (hospitals/clinics) which cause delays in SAR adjudication.	All
3	More detailed management information is needed to more effectively manage the service authorization process.	All
4	Some CCS Program standards imposed on counties make it more difficult for counties to efficiently process SARs.	All
5	Some counties submit incomplete SAR information to the SRO for SAR processing; this causes delays in service authorization and requires extensive follow up effort with the county.	Dependent Counties

## Best Practices

DHCS initiated an independent review of CCS county-level operations to identify best practices that could be implemented as policy by DHCS' CCS Program. The review noted the following policies and actions that DHCS may implement to improve SRO SAR processing:

1. Administrative Denial Process  
Counties with the smoothest operation and lowest backlog administratively deny SARs that are submitted with incomplete information.
2. Electronic Fax (e-FAX) System to Receive Service Authorization Requests  
Efficient counties utilize an electronic e-FAX system which eliminates the need for maintaining hard copy documents.
3. Electronic Request Process  
Efficient counties have converted from a paper driven to an electronic request process.

4. Rapid Eligibility Determination Process  
Some counties have developed what they refer to as a rapid eligibility determination team process which enables counties to quickly determine eligibility on more routine requests.
5. Algorithms Are Used to Help Nurses Make Decisions  
More efficient counties have developed a predetermined set of clinical guidelines that permit quicker medical eligibility determination.
6. Effective Use of Extended SAR Authorization Periods for Specific Diagnoses  
Some counties approve extended SAR authorization periods, consistent with the client's health needs, to avoid repeated authorizations for the same reason.

#### Operation/Organizational Improvements

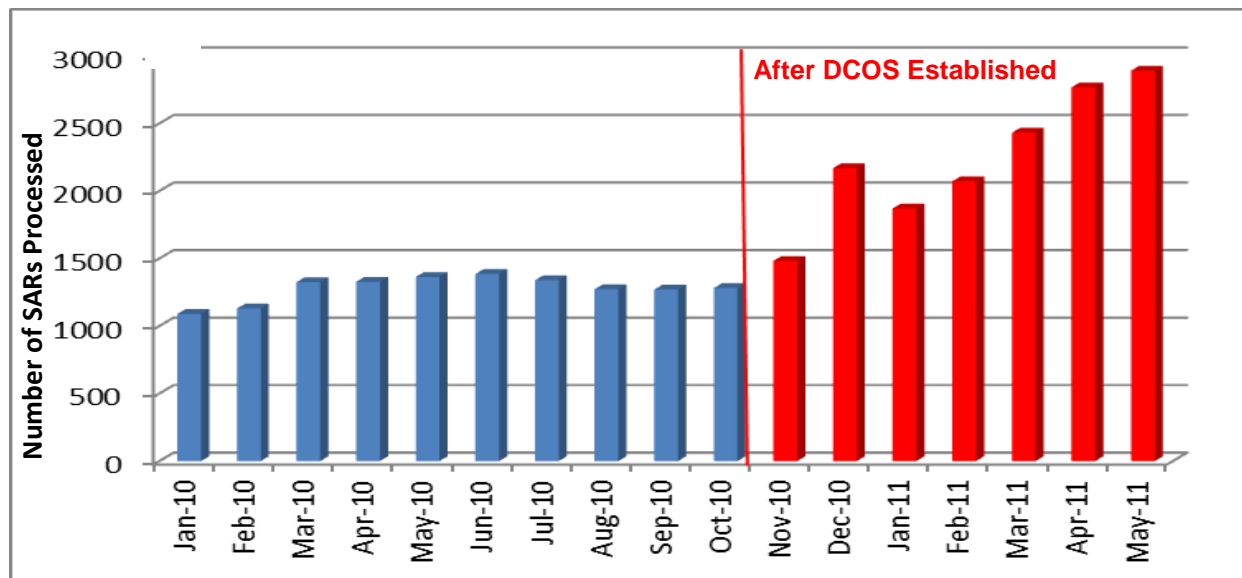
In addition to potential best practices improvements, DHCS has identified 15 operation and organizational improvements; 7 improvements are currently implemented or in the process of implementation and 8 improvements are under development. These improvements address the issues identified in the Audits and Investigations Division findings and the SCD best practices analysis.

#### **Currently Implemented**

1. Dependent County Operations Section (DCOS)  
SCD created the DCOS for the purpose of addressing dependent county issues. This new section now manages the Sacramento office that makes medical eligibility determinations for the dependent counties. Dependent counties (counties with populations of 200,000 or less) are responsible for determining financial and residential eligibility for prospective and existing CCS clients. The section is responsible for determining CCS medical eligibility for these same counties. The creation of this section permits easier identification and development of standardized processes across all counties, easier identification of systemic related processing issues, and facilitates quality improvement in the SAR process.
2. CMSNet Acknowledgement of SARs  
CMSNet is being used more effectively to acknowledge when a SAR is forwarded to the state CCS Program for medical eligibility determination. This is accomplished in an automated process via the CMSNet case management system.
3. Temporary "Strike Team" for SARs  
The DCOS created a team of cross-trained staff to temporarily redirect and eliminate backlogs identified in the SAR process. The first use of the "Strike Team" was to assist SRO to process medical eligibility for the dependent counties.

Results of initial business process reengineering has successfully improved the morale of the CCS Program staff and improved the SAR production in SRO. SAR processing production has increased by 126 percent after DCOS was established and a manager was assigned to dependent county concerns and issues. The bar graph below depicts this improvement.

### Sacramento Regional Office SAR Production Results



Source: CMSNet Database

#### 4. Major Reorganization of SAR Filing System

A reorganization of the filing system was implemented to more easily identify duplicate SARs and CCS applications and facilitate improved SAR processing. As the electronic submission of SARs begins to phase in, paper copy client records will be eliminated.

#### 5. Single Point-of-Contact for Clients, Providers, and Counties

The DCOS manager is the single point-of-contact until a Rapid Eligibility Determination (RED) Team can be fully implemented.

#### 6. Reconnecting with Dependent County Administrators

The CCS Program began visiting dependent counties and has reinstituted recurring dependent county meetings to discuss issues and new processes.

#### 7. CMSNet SAR Production Report

SRO has developed and begun implementation of a CMSNet SAR Production Report to better track SAR processing trends and issues. The report's data can be sorted by county.

## **Under Development**

### **1. Use CMSNet to Track SARs**

Modifying the CMSNet data entry fields and standardizing associated processes and definitions will allow better statewide tracking of all clients through the SAR process.

### **2. SAR Production Reports**

The CCS Program will further develop the CMSNet SAR Production Report to better track SAR processing trends and issues that can be sorted by provider and county. This second version will permit the ability to: (a) track the number of SARs by county and processor (daily, weekly, monthly, quarterly, yearly); (b) track and sort the number of SARs by provider and county, (c) track the number of SARs by service type such as inpatient, outpatient and physician services; and (d) create an aging report for SARs in 30/60/90/120 day cycles that also collects data by initial referral, financial/residential eligibility, medical eligibility determination, and SARs forwarded by dependent counties.

### **3. RED Team**

Develop a RED team to quickly determine eligibility and identify and track potential inappropriate referrals due to the use of incorrect forms, lack of medical eligibility, etc. Inappropriate referrals are made daily to all counties; tracking these referrals in CMSNet will allow the CCS Program to alter inappropriate referral patterns.

### **4. Mandatory Use of SAR Form**

Work with counties to require the use of the standardized SAR referral form for all dependent and independent county referrals. Providers currently send in referrals with incomplete information, which requires county and state staff to complete this work. Comparatively, the Medi-Cal Treatment Authorization Request (TAR) process requires providers to submit completed requests prior to review for approval.

### **5. Create an Electronic SAR Submission Process (e-FAX process)**

A new SAR processing procedure will be developed to complete all electronically submitted SARs. This more efficient use of technology will allow for improved flexibility to address unexpected changes in priority and utilize all resources to process SARs. A soft copy of a SAR can be securely routed between workers using an Internet-based system instead of moving hard copy paper between desks and offices.

### **6. Revise How SARs are Assigned**

Use of an e-FAX process allows for greater efficiency in assigning SAR workload to staff in various offices within the state. A soft copy of a SAR can be securely routed between workers using an Internet-based system instead of moving hard copy paper between desks and offices.

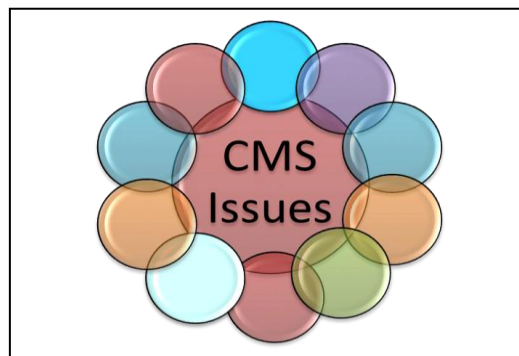
7. Use of Extended SAR Authorization Periods (e.g., diabetic supplies)

The CCS Program will implement a consistent SAR procedure that permits approval of certain SARs for greater periods of time when analysis of the health condition meets predetermined clinically-approved guidelines. This practice will help to reduce the number of total SARs that typically require repeated authorizations for the same reason.

8. Stakeholder Engagement (Venn Group)

The intent of the Venn Group process is to engage counties and stakeholders on various program issues including improving the SAR process. It will use a standard collaborative public policy process to engage stakeholder groups using representation in one group instead of multiple stakeholder group meetings.

These long-term improvement solutions require a collaborative public policy process due to the complexity of issues and the diverse ways counties currently handle these topics. A Venn subgroup, created to address SAR issues, met for the first time on April 6, 2011, and will continue to meet on a scheduled, recurring basis. Initial discussion points included: (a) pending status standardizations; (b) SAR acceptance procedures; (c) financial and residential standardization; (d) improved reporting capabilities; and (e) regionalization of dependent counties for SAR production.



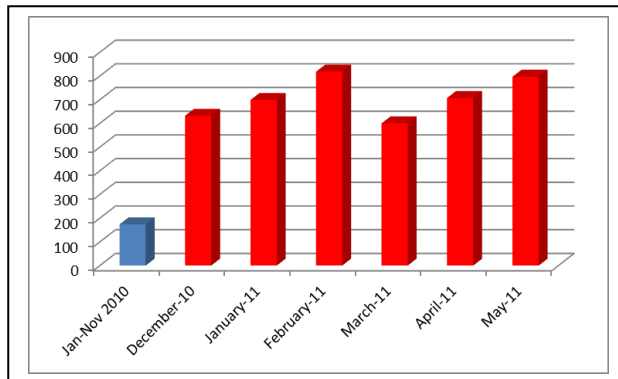
A larger Venn Group will be assembled to address longer term solutions for improving core business processes and practices, in addition to operational issues such as consistent statewide medical eligibility criteria for all counties, and case management best practices.

### **III. Review of the CCS Provider Certification and Enrollment Process**

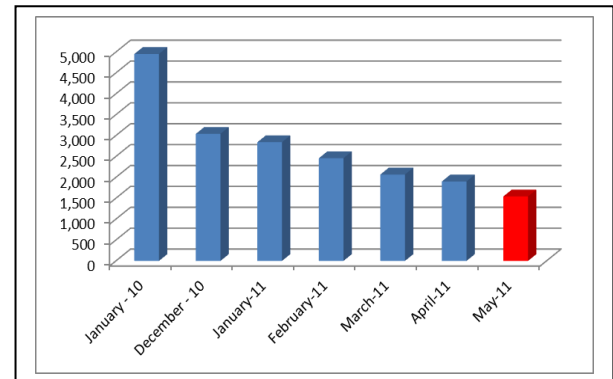
The CCS Program employs and maintains program standards of care including standards for physicians and other providers who provide health care services to CCS-eligible clients. This process is generally referred to as “provider paneling.” The provider paneling process was also included in the program review conducted by DHCS’ Audits and Investigations Division.

An initial analysis of the provider enrollment process revealed that the CCS Program had approximately 5,000 applications backlogged as of January 2010. For the first 11 months of 2010, the CCS Program processed an average of 174 applications per month while receiving between 325 and 575 applications per month. As of May 31, 2011, the CCS Program increased the number of applications processed per month by an average of 307 percent and reduced the application backlog from 4,954 to 1,544. A temporary Strike Team concept was used to make the initial improvement.

**Applications Processed per Month**



**Applications in Queue**



Source: DHCS Panel Me Database

The reduction in application backlog and increase in processing was accomplished using the following strategies.

1. Redirection of a temporary Strike Team to assist with the backlog
2. Development of a new tracking process for application review and monitoring
  - a. Provide (daily, weekly, monthly, quarterly, and yearly) tracking.
  - b. Begin monitoring SAR processing with a 30/60/90/120 day aging report.
3. Future plans include moving to a paperless process
  - a. Accept applications via electronic e-FAX in the short-term and via Internet by December 2011.
  - b. Revise the provider notification process. Currently each provider receives a hard copy letter apprising him/her of the CCS Program's decision about their CCS provider application. This process is cumbersome and does not effectively use technology for this notification. By September 2011, the CCS Program will develop a process for an applicant to apply and review approval via the Internet and allow automated printing of an official notification. The hard copy letter announcing status currently utilized will be discontinued.
  - c. Review how to utilize medical staff data in hospitals to authorize providers. Currently all hospital medical staff continuously review each provider affiliated with the facility. It may be possible to utilize medical staff approvals to approve CCS providers. The use of the CCS Program's newly revitalized facility and county review process to audit accuracy of provider paneling is contingent on this process.

#### **IV. Review Medical Eligibility Processing**

The application of consistent medical eligibility criteria within independent counties and dependent counties across California has been a long-standing issue in the CCS Program. This, in turn, has affected quality processing of SARs. To improve this situation, SRO will use algorithms to more consistently make decisions about approvals or denials of SARs without the currently required continuous intervention by SRO physicians. Supervising clinical nurses will monitor the quality and appropriateness of algorithms and coach or train staff based on quality assurance findings.

Additionally, a quality assurance process was instituted in November 2010, for adjudication of all medical eligibility denials. To date, the CCS Program has seen a success rate of 99 percent; that is, less than 1 percent of the denials have been overturned by the CCS Program's Chief Medical Officer. Improved quality assurance data analysis will be implemented by August 2011, to help improve medical eligibility processing. A statistically significant sample of approved and denied SARs will be identified and reviewed for medical appropriateness. Immediate coaching will be used if required, and trends will be identified for training opportunities and potential policy changes.

The CCS Program's Chief Medical Officer has instituted statewide meetings of the County Medical Consultants in order to obtain consensus and develop an implementation strategy to ensure a consistent, evidence-based approach to medical eligibility issues.

#### **V. Oversight and Monitoring Program**

SRO, in recent years, has not been organized or adequately staffed to effectively perform oversight and monitoring functions related to providers, facilities, and county operations. As such, SCD implemented a reorganization of operations on March 2, 2011, and created the Independent County Operations Section (ICOS). A part of the new ICOS will be devoted to oversee and monitor providers, facilities, and county operations.

1. The CCS Program created the new ICOS. SCD reorganized to more efficiently utilize existing resources to form this new Section and improve the oversight and monitoring of county operations, facilities, and providers. As a result of this reorganization plan, the CCS Program will be in a position to conduct approximately 170 site visits per year, which will include reviews of:
  - a. 58 Counties (every 3 years);
  - b. 338 Hospitals (every 5 years);
  - c. 124 Neonatal Intensive Care Units (every 5 years);
  - d. 24 Pediatric Intensive Care Units (every 5 years); and
  - e. 249 Specialty Care Centers (every 5 years).

2. The CCS Program's Chief Medical Officer is reviewing ways to streamline the monitoring and review process and eliminate additional review requirements of facilities that were reviewed during construction and licensure.
3. The existing database is currently being redeveloped to better track all facility providers. This improvement will permit more efficient monitoring of provider paneling in facilities by providing a checks and balance system during site reviews. This database will also allow the CCS Program to run regular reports that identify all site reviews well in advance of the review date. This process will allow more effective staffing of site review teams with all nurses on staff, thus maximizing job diversity and satisfaction.
4. ICOS will also process Early and Periodic Screening Diagnosis and Treatment (EPSDT) TARs and perform back-up for the Site Review and SAR processes. It is estimated that approximately 10,500 EPSDT TARs will be processed annually.

All non-CCS Medi-Cal eligible children in California receive health screening and evaluation services from an approved medical provider, including a physical examination, immunizations appropriate for the child's age and health history, and laboratory procedures appropriate for the child's age and population group. EPSDT TARs are requests to perform services for these children, and will be directed to the newly established ICOS for processing.

#### **VI. Identification of Best Practices for Case Management and Care Coordination Functions including Discharge Planning**

An integral part of Phase 2 is to improve the core business processes and practices of the CCS Program by convening a statewide Medical Consultant Group, representing all CCS Program counties. This group will begin addressing case management best practices and medical policy to improve care. The initial list of issues to discuss includes:

1. Neonatal Intensive Care Unit;
2. Respiratory Syncytial Virus Immunoprophylaxis;
3. Trauma/Emergency Medical Services for children;
4. Medical eligibility;
5. Palliative care;
6. Hemophilia management; and
7. 1115 Waiver outcomes.

#### **VII. Identification of Opportunities for the Use of Web-based Tools, Telemedicine, E-prescribing, and other Technologies to Reduce Costs and Streamline**

Recommendations for program improvement include the use of technology to improve business processes, where possible. In Phase 1, initial short-term changes have begun, and SCD and internal partners are collaborating to identify the requirements necessary for CCS Program inclusion in the design, development and

implementation of the California Medicaid Management Information System replacement system. The planned replacement by ACS, Inc., the new Medi-Cal fiscal intermediary, will offer state-of-the-art upgrades in SAR processing, case management, eligibility determination, electronic provider inquiry, and monitoring and reporting capabilities.

In Phase 2, the CCS Program's Chief Medical Officer will utilize the statewide Medical Consultant Group, representing all CCS program counties, to define how telemedicine and e-prescribing will function within the state. We anticipate Phase 2 will get started in early 2012.

## **VIII. Conclusion and Recommendations**

DHCS has begun improvement of the core business processes and practices of the CCS Program SAR processing, provider paneling and enrollment process, medical eligibility process, oversight and monitoring, identification of best practices associated with case management, and identification of opportunities for the use of information technology. The CCS provider certification and enrollment results show that the first steps in improvement have been noticeably successful. The use of stakeholders in the Venn Group process will help ensure continuous quality improvement in the CCS Program.

### Next Steps

1. Continue to analyze county operations and explore "out-of-the-box" solutions to streamline operations.
2. Convene Medical Consultant group meetings to address case management, best practices, and medical policy to improve care.
3. Convene a broader stakeholder group to address critical program issues facing the CCS Program.
4. Continue system analysis of core business processes and practices of the CCS Program and the other CMS Branch programs, including but not limited to, Genetically Handicapped Person's Program, Health Care Program for Children in Foster Care, and the Newborn Hearing Screening Program.
5. Continue the improvement in the use of technology to streamline the CCS Program processes.
6. Develop a facility database to integrate site visit and approval processes.
7. Integrate medical eligibility algorithms into the SAR process, and monitor quality outcomes.
8. Implement a Pediatric Intensive Care Unit database to be used as basis for quality improvement.
9. Develop a quality outcomes process for CCS Program pilot projects under the DHCS Bridge to Reform 1115 Waiver.
10. Continue consideration of California Perinatal Quality Care Collaborative-derived data for CCS Program process improvement.